



In order to learn more about your general state of health, we ask you to take a few minutes and complete the following questions before you see your doctor. This will allow your doctor to spend less time asking general questions and spend more time focusing on your problem and treatment options. Thank you for your assistance, and please bring this completed form with you to your first radiation oncology visit.

Patient Name	Date of Birth			
MR#		Date of Service		
(Office Use Only – Do Not Complete)	olete) (Office Use Only – Do Not Compl			
Medical History				
Do you have or have you had?				
Yes No	Yes No			
Diabetes Lung Prob		Regional Enteritis		
High Blood Pressure Kidney Dis	sease	Hepatitis	-	
Heart Problems Gout		Jaundice	-	
Stroke Stomach P		Cancer	-	
<del></del>	er Problems	Hormone Therapy		
<u> </u>	diverticulosis	Chemotherapy	-	
Anemia Chron's Di	sease	Previous Radiation	_	
Asthma Lupus	<del></del>	Scleroderma	_	
Other				
Hospitalizations: (Please include illnesses, injurie Reason	s and surgeries)	Location		
Reason	Date	Location		
Reason	Date	Location		
Family History:				
Age Alive? Major III	ness/ Cause of Death			
Mother Yes No				
Father Yes No			_	

Siblings Yes No		
Siblings Yes No		
Siblings Yes No		
Children Yes No _		
Children Yes No		
Has anyone in your family had?		
Cancer Yes _	No What Type	
Heart disease Yes	No What Type	
Liver disease Yes	No What Type	
	No What Type	
_	No What Type	
· —	No What Type	
	No What Type	
Social History:		
Do you drink alcohol? Yes N	No Amount	
Do you use tobacco? Yes I	No Amount	
Please complete the following questi	ons:	
Have you noted any recent changes v	with: Weight gain or weight loss	Vos No
		Yes No
(Constitutional)	Feeling too hot or too cold	Yes No
	Always feeling hungry or thirsty	Yes No
	Problems with sleeping	Yes No
Do you have any problems with:	Headaches	Yes No
(Head and Neck)	Dizziness or lightheadedness	Yes No
,	Thyroid Problems	Yes No
	Lumps or swelling in the neck or shoulder	 Yes No
	Sore throat	Yes No
	Swallowing	Yes No
	Soreness of the neck or shoulder	Yes No
Do you have any problems with:	Recent changes in vision	Yes No
(Eyes)	Blurred or double vision	Yes No
• • •	Cataracts	Yes No
Do you wear glasses or contact	Glaucoma	Yes No
Lenses? Yes No	Eye infections	Yes No
Do you have any problems with:	Changes in hearing	Vos. No.
Do you have any problems with:	Changes in hearing	Yes No
(Ears, Nose and Throat)	Buzzing or ringing in the ears	Yes No
	Frequent earaches or ear infections  Motion sickness	Yes No Yes No
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Do you wear dentures? Yes No  Do you have any problems with: (Respiratory System)	Frequent sinus problems or colds Recurrent nose bleeds Mouth pain or difficulty chewing Bleeding gums or mouth sores Taste change Hoarse voice or difficulty talking  Asthma Tuberculosis	Yes Yes Yes Yes Yes Yes Yes	No No No	
(Respiratory System continued)	Bronchitis or pneumonia Difficulty or painful breathing Shortness of breath at rest Cough Night sweats	Yes Yes Yes Yes Yes	No No No	
Ca Ha Ha If Ha	ore you are out of breath? as this changed recently? an you climb a flight of steps without resting? On how many pillows do you sleep? ave you had a cough that has lasted for more that ave you coughed up phlegm daily for more than yes, what color was the phlegm? ave you had a skin test for TB? That was the result?	2 weeks?	No	No No No No gative
Do you have problems with: (Cardiovascular System)	Chest pain Palpations or irregular heart beat Heart murmur Heart failure Ankle swelling High cholesterol or		Yes Yes Yes Yes Yes Yes	No No No No No No
	Nausea or vomiting Vomiting blood Constipation Black stools Blood in stools Diarrhea pes food ever get stuck, come back up, or make yow many bowel movements do you have per day		Yes Yes Yes Yes Yes Yes	No No No No No No
Do you have problems with: (Musculoskeletal System)	Bone or joint pain Joint swelling or stiffness Muscle pain or weakness Sciatica Broken bones ave you ever been told you have lupus or arthrit	is?	Yes Yes Yes Yes Yes Yes	No No No No No
Do you have problems with: (Neurological System)	Weakness in the arms or legs Changes in coordination or balance Paralysis or numbness Shaking or tremors	2	Yes Yes Yes Yes	No No No No

	ŀ	Head injury	Yes	No
	l	oss of consciousness or passing out	Yes	No
		Seizures or fits	Yes	No
	[	Difficulty in working with numbers	Yes	No
	]	Difficulty thinking of words	Yes	No
	]	Difficulty speaking	Yes	No
	(	Changes in memory	Yes	No
	(	Changes in handwriting	Yes	No
		Difficulty in holding a pen, pencil or cup	Yes	No
Do you hav	re problems with:	tching or burning of the skin	Yes	No
(Skin)	E	Easy bruising or bleeding of the skin	Yes	No
	9	Sores or rashes	Yes	No
Do you hav	re problems with:	ack of concentration or memory	Yes	No
(Mood)	]	Difficulty relaxing	Yes	No
	l	oss of temper	Yes	No
	E	Being annoyed by little things	Yes	No
	E	Excessive worrying	Yes	No
	E	Excessive crying	Yes	No
	(	Change in personality	Yes	No
Do you have problems with:		Painful or frequent urination	Yes	No
(Genitourir	nary System) [	Difficulty emptying your bladder	Yes	No
	9	Split stream or difficulty controlling urination	Yes	No
	]	Difficulty starting urination	Yes	No
	l	Jrgency to urinate without warning	Yes	No
	[	Oribbling or loss of control of urine	Yes	No
	E	Blood in urine	Yes	No
	ŀ	Kidney stones	Yes	No
		/enereal disease (VD)	Yes	 No
	,	/enereal warts	Yes	 No
	Do you experience night	time urination?	Yes	 No
		then have to go again in less than ½ hr?	Yes	No
For Men:	Have you noticed any change in sext	ual function over the last 2 years?	Yes	No
	Date of last rectal examination	Date of last physical exam	ination	
For Wome	<u>n:</u> Have you ever been pregnant? Yes	No If yes, how many time	s?	
	Did you have any problems with pre	gnancy? Yes No Number of chil	dren:	
	Have you gone through menopause?	? Yes No If yes, how old were	e you?	
	, ,	irge from the vagina? Yes No		
	Have you ever had any operations o	r infections of the uterus, fallopian tubes or ov	aries?	Yes No _
	Do you have any lumps, swelling or t		Yes	No
	Do you have pain or bleeding with se			No
	Date of last pelvic exam:	Date of last PAP smear:		
	Date of last breast exam:	Date of last mammogram		
	Date of last general physical examination	ation		

## Please do not write below this line For Physician Use Only All other systems are negative Review of systems unobtainable Reason: History obtained from (other source) No other source available (Problems with positive or pertinent negative findings must be individually documented) (Problem pertinent = 1 system, Extended = 2 to 9 systems; Complete = 10+ systems)

Date

Attending Physician's Signature

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